REHABILITATION FACILITIES (INPATIENT) PAYMENT SYSTEM

*payment***basics**

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After an illness, injury, or surgical care, some patients need intensive inpatient rehabilitation services, such as physical, occupational, or speech therapy. Relatively few beneficiaries use intensive rehabilitation therapy because they generally must be able to tolerate and benefit from three hours of therapy per day to be eligible for treatment in an inpatient rehabilitation setting. Inpatient rehabilitation facilities (IRFs), may be freestanding hospitals or specialized, hospital-based units. Medicare payments to IRFs were an estimated $6.7 billion in 2005. Medicare accounts for about 70 percent of IRF cases. In 2004, Medicare beneficiaries had 497,000 discharges from IRFs, and about 1,200 facilities were Medicare certified.

Beneficiaries transferred to an IRF from an acute care hospital pay no additional deductible. However, beneficiaries admitted from the community are responsible for a deductible—$952 in 2006—as the first admission during a spell of illness, and for a copayment—$238 per day—for the 61st through 90th days. Beneficiaries treated in IRFs use their hospital days, thus are covered for 90 days of hospital care per illness, with a 60-day lifetime reserve.[1]

Beginning in January 2002, IRFs are paid predetermined per-discharge rates based primarily on the patient's condition (diagnoses, functional and cognitive statuses, and age) and market area wages. Before then, IRFs were paid for furnishing care to Medicare beneficiaries on the basis of their average costs per discharge, as long as they did not exceed the facility-specific limit that was adjusted annually.

Under the prospective payment system (PPS), discharges are assigned to case-mix categories organized by clinical problems and expected resources. Each case-mix category has a national relative weight reflecting the expected relative costliness of treatment for patients in that category compared with that for the average Medicare inpatient rehabilitation patient.

Defining the inpatient rehabilitation products Medicare buys

Under the inpatient rehabilitation PPS, Medicare sets payment rates for 353 intensive rehabilitation products—called case-mix groups (CMGs)—defined by types of treatment episodes. Patients are assigned to 348 of these treatment categories based on the primary reason for intensive rehabilitation care (for example, a stroke or burns); their age and levels of functional and cognitive impairments; and the types of comorbidities (co-existing conditions) present during the stay. The other five categories are for patients discharged before the fourth day—called short-stay outliers—and for those few who die in a facility. Further, IRFs may receive lower payments for other patients who are discharged to another facility and the length of stay is less than that typically provided to patients with the same condition.

Setting the payment rates

The PPS payment rates cover all operating and capital costs that IRFs would be expected to incur in furnishing intensive rehabilitation services. The base rate—$12,981 for fiscal year 2007—is adjusted for area wages by multiplying the labor-related portion of the base payment amount—76 percent—by a version of the hospital wage index and the result is added to the nonlabor portion (Figure 1). The sum is then case-mix adjusted by multiplying the local base rate by the relative weight for the CMG to create the PPS payment rate for each patient.

Payment rates are increased for IRFs located in rural markets, that treat low-income patients, and that are teaching

This document does not reflect proposed legislation or regulatory actions.

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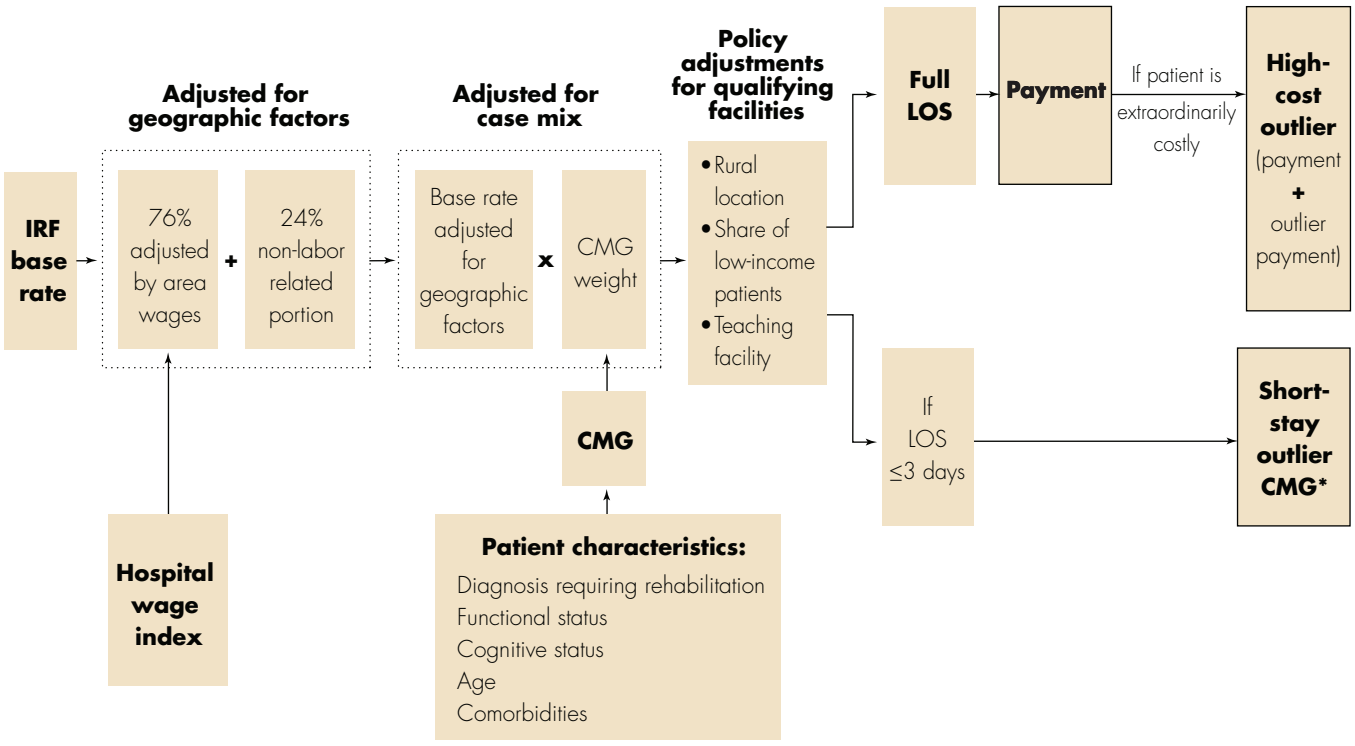
Figure 1 Inpatient rehabilitation facility prospective payment system



Note: IRF (inpatient rehabilitation facility), CMG (case-mix group), LOS (length of stay).
*IRFs with a wage index of 1.0 are paid $2,809 for short-stay outliers.

institutions. Rural facilities' payment rates are increased by 21.3 percent because they tend to have fewer cases, longer lengths of stay, and higher average costs per case. An IRF's payments are adjusted for the share of low-income patients it treats—the adjustment is based on the sum of two proportions: the proportion of total Medicare days furnished to beneficiaries eligible for Supplemental Security Income benefits and the proportion of total patient days furnished to Medicaid patients not covered by Medicare. Unlike acute care hospitals, IRFs do not have to reach a threshold of the share of low-income patients before payments are adjusted. Payments for IRFs that are teaching institutions are adjusted according to the ratio of their residents to their average daily census.

IRFs have two outlier policies. One is for patients with short stays (less than or equal to three days) for which IRFs are paid lower rates—in fiscal year 2007, $2,857 for an IRF with a wage index of 1.0. The other is for high-cost outliers when costs exceed a fixed-loss threshold. This outlier threshold is the regular payment rate plus a national fixed-loss amount ($5,534), adjusted by the wage index. For high-cost outliers, IRFs receive their regular payment rates plus 80 percent of their costs above the fixed-loss threshold. Total outlier payments are estimated to be 3 percent of spending for IRFs.

Both the base rate and relative weights are updated annually. The base rate is updated using the market basket index with capital used for facilities originally excluded from the acute care hospital PPS (IRFs, long-term care hospitals, inpatient psychiatric facilities, cancer, and children's hospitals). The relative weights are updated based on changes in national average charges per discharge for each CMG.

The 75 percent rule

The 75 percent rule is a criterion used to define inpatient rehabilitation facilities in order for them to receive payment as an IRF. The rule requires that 75 percent of cases an IRF admits have one or more selected conditions. For cost reporting periods beginning on or after July 1, 2004, the rule expanded, from 10 to 13, the number of qualifying medical conditions used to classify a facility as an IRF. The 13 conditions are:

- stroke
- spinal cord injury
- congenital deformity
- amputation
- major multiple trauma
- hip fracture
- brain injury
- neurological disorders (e.g., Multiple Sclerosis, Parkinson's)
- burns
- three arthritis conditions for which appropriate, aggressive, and sustained outpatient therapy has failed, and
- joint replacement for both knees or hips when the surgery immediately precedes admission, when body mass index ≥50, or age 85+.

At the same time, CMS phased in the percentage needed to qualify as an IRF using the 13 conditions:

- For cost reporting periods beginning on or after July 1, 2005, and before July 1, 2007, 60 percent of the IRF's total patient population must be from these diagnoses; and
- For cost reporting periods beginning on or after July 1, 2007, and before July 1, 2008, 65 percent of the IRF's total patient population must be from these diagnoses.

During this phase-in, CMS will monitor the impact of the revised criteria, including patients' access to care, and promote research to identify patients and medical conditions that most need intense rehabilitation services as provided by IRFs. On July 1, 2008, the threshold will return to 75 percent. During the phase-in, the rule:

- Established that if a facility's Medicare population meets the threshold, the facility's total population does as well.
- Allowed secondary medical conditions to meet the 13 medical conditions that qualify towards the threshold. The secondary condition, even in the absence of the admitting condition, must cause a significant enough decline in the patient's functioning that the individual would need intensive rehabilitation services best provided in an IRF.

Annual update and policy changes

On August 18, 2006, CMS published a final rule to update PPS rates for IRFs beginning October 1, 2006. The rule:

- Updates IRF payments by 3.3 percent and reduces payments by 2.6 percent to adjust for coding changes, for a net increase of 0.6 percent. ■

1 Beneficiaries are liable for a higher copayment for each lifetime reserve day—$476 per day in 2006.